When you get a case that is going to be one of posterior presentation, if you diagnose it early it is possible to rotate the head before it is engaged.

Dr. Geo. Cole, Los Angeles—Within a day or two before coming here I saw an article on the same subject. In speaking of these cases the writer advised two maneuvers: One was that as soon as the diagnosis was made in the early stage, the patient should remain in genu pectoral position and that the position of the body would often help to a better position, which I think is overdrawn, because I think the change of position takes place in the early stages, not when the head gets down near the perineum. But as to whether that position is of benefit or not, I am not able to say. The other suggestion was, in applying the forceps put them on in the reversed position; put the convexity to the front. His object in doing that was to make more perfect flexion. The point of the blades were pointed down directly toward the rectum, and while in the hands of a very suitable man this might be tried, yet to my mind it would simply result in injury to the rectum. In many cases we find a position where there is a large roomy pelvis and moderately sized child. Leave them to nature and the application of forceps becomes an easy matter. But where there is a small pelvis and a large child, it is exceedingly difficult.

WAS IT A CASE OF MENINGEAL HEMORRHAGE, HYSTERIA OR MALINGERING?*

By H. J. B. WRIGHT, M. D., San Jose.

TO the general practitioner the obscure cases of hysteria and the cases of malingering are often embarrassing and sometimes hurtful. Until the stability of the nervous system is greatly increased and cupidity as greatly decreased, we may expect to find cases of hysteria and malingering. Medico-legal literature contains abundant evidence of the credulity and ignorance of physicians when dealing with hysterical and malingering patients. A study of the following case may assist us in our efforts to learn how to escape from the pitfall of hysteria and the tricks of the malingerer.

It should be known at the outset that the patient is a medical gentleman who has done much surgical work, and who is familiar with the anatomy and physiology of the human body, and is thereby more capable of deceiving his medical attendant than the untutored person would be. There is also a psychological possibility in the case which should not be overlooked. The patient is carrying an accident insurance policy which gives an indemnity of $100 per week for a period of 102 weeks. Should the disability of the policy-holder continue through that period, the accident company will be liable for the sum of $10,400. The question before us is not whether the company is liable, this being a purely commercial question, but whether the hope of gain has psychologically caused the patient to exaggerate his sufferings without being guilty of intentional wrong.

Fifteen physicians, all gentlemen of ability, have seen this patient, and at least two of the number have recently expressed themselves as believing the patient was not seriously injured. Of the others, one said: "It is a case of concussion of the brain"; another said: "It is a case of voluntary convulsions," and three said: "It is a case of meningeal hemorrhage," while another said: "It is a case of shock resulting in hysteria, or traumatic hysteria."

The opinions of these medical gentlemen are not to be pooh-poohed, for they are the opinions of men who have much diagnostic ability. Unfortunately, one of these medical gentlemen, who studied the case for several weeks, expressed an opinion which called in question the veracity and honesty of the patient, and incurred the displeasure of the patient's wife, who gave the doctor a public horsewhipping. The patient's family history contains nothing of importance in this connection. The personal history shows a large and varied experience in the affairs of life. He lost a little finger and the corresponding metacarpal bone of the left hand, through a gunshot wound. He had septicemia a few months before the present illness. From this he completely recovered, except that it left the skin of the anterior portions of his chest quite discolored by irregularly deposited pigment. At the time the injury, the effect of which we are to study, was received, he was in the full vigor of manhood, at the age of fifty-nine.

July 8th, 1902. While riding in a railway coach, with his elbow on the open window sill and his chin in his hand, he cried out that something had struck him and that he was in great pain. A physician, who was near, found a bluish colored, irregular circular spot about one inch in diameter, over the right coronal suture, about three inches below the median line of the head. There was no abrasion, nor did palpation give any evidence of fracture of the skull. A stone the size of a man's fist was found near the patient. At the end of about twenty minutes the patient lost consciousness, and had a number of convulsions, general in character. The comatose condition continued for 36 hours, during which time patient had many convulsions. At the end of 48 hours his mind was clearing, the pupils were dilated and left hemiplegia was discovered.

On the 5th day he had difficulty in speaking, but the nurse's notes do not disclose the nature of the difficulty. The convulsions continued to recur at irregular intervals.

On the 7th day the temperature, which before had been normal, rose to 100 2-10, pulse 74, respiration 27. He complained of pain in right side of head and in right ear. During the convulsions, which were less severe than at first, the facial muscles twitched and froth appeared between the lips.

The notes do not state whether the muscles on the left side of the body were involved in the convulsive movements at that time or not.

On the 8th day the temperature was 100, pulse 66, mind weak.

The 9th day the patient had 33 convulsions. He was always unconscious during these paroxysms.

The 12th day, ophthalmoscopic examination showed normal or slightly pale fundus, nothing wrong with the media, but there was hemiopsia of nasal side of right eye, the vision of left eye being undisturbed.

* Read at the Thirty third Annual Meeting of the State Society, Santa Barbara, April 21-23, 1903.

About this time the nurse says she saw the patient carry his left hand and forearm from under the bed-covering and place it over the abdomen.

August 6th. Temperature 103, leeches applied to head.

August 8th, 1902, or 20 days after receipt of injury, patient was first seen by the writer. Decubitus dorsal; patient well nourished; skin clear except as above noted; nothing characteristic about facial expression; ideation is impaired; slight aphasia: unable to recall anatomical terms with which he was quite familiar before the injury; pupils normal in size and reaction to light. There is absolute loss of vision in nasal one-half of right eye; vision of left eye normal. There appears to be complete loss of voluntary motion of the left upper and lower limbs, which are anesthetic and analgesic. A needle plunged under the left thumb-nail causes no pain; patelar-tendon-reflex exalted on both sides; plantar-reflex acute on right side and nil on left side. The convulsions now consist of muscular waves which run over the platysma myoides, the sterno-cloide-mastoids and possibly some other muscles of the cervical region, throwing the head forward and somewhat to the left. At the same time the levator-palpebrae superiorii and the occipito-frontalis muscles elevate the brows and upper lids, causing the palpebral fissures to be peculiarly broadened; the eyeballs are, at the same time, rolled downward. These irregular muscular movements are coincident with loss of consciousness. The seizures last from one to three minutes.

22d day. Temperature 101, pulse 80, respiration 32; today he had clonic convulsions involving the cervical muscles and also those of the right side of the body, while the paralyzed members remained in a quiescent state. These convulsions are peculiar in this: they are broken by periods of repose which last from one-half to two minutes, when the convulsive movement begins again to be soon followed by another period of repose. These convulsive cycles last from five to ten minutes. Today the patient throws himself about in a violent manner, necessitating restraint; cantharidal-vesicant was applied to head and blood soon appeared in urine attended with strangury.

Fourth week. The cervical muscles are not now involved in the convulsions. The temperature today is 101, pulse 100, respiration 16, face pale. During the past two weeks he has voided from 12 to 18 ounces of urine daily, the specific gravity ranging from 1020 to 1028.

August 25th. Today he had spasm of right calf and delirium, the respirations during the seizure running from 40 to 50 per minute.

August 27th, 1902. Fifth week. The respiratory act was greatly disturbed today. At 3 A. M. the respirations numbered 60 per minute; at 4 A. M. they were 20 per minute; at 5 A. M. they were 16 and at 5:30 A. M. they numbered 60. During the seventh week the temperature, pulse and respiration were about normal. The convulsions are frequently preceded by sensory aura in the right side of head, which is described by the patient as traveling to the ear and immediately thereafter he becomes unconscious. Electro muscular reaction is normal in the skeletel muscles of the right lateral one-half of the body. The left deltoid and the left biceps and the left quadriceps extensor respond very slightly to the faradic current. All other muscles of the left lateral one-half of the body are unaffected by this current.

Eighth week. Convulsions recur only at night. The daily secretion of urine rarely exceeds 8 ounces. It is free from blood, sugar, albumen and casts. The spot where the stone is supposed to have struck is hypersensitive. The patient is now able to lift left elbow until arm stands at right angles to the body.

November 24. Has frequent attacks of vertigo and sometimes vomits. The hemiopia has entirely passed away. Patient is pleased to show his improved condition. Electro muscular reaction is almost nil in trapezius, latisimus-dorsi, erector-spina-mass the flexors and extensors of forearm and hand and the muscles of the leg and foot of the left side. The electro sensory function is present to a slight degree in left arm and left thigh, absent in left forearm, hand, leg and foot; the left ankle is edematous.

February, 1903. Patient is much improved. The nocturnal convulsions return at intervals of from three to five nights; they are similar in character to those of the past, coming on generally during sleep and as often passing away without awakening the patient. At the commencement of the attack the patient utters a peculiar cry and immediately has clonic convulsions affecting right lateral one-half of the body and the facial muscles. The convulsive movements of the right side of body being unapposed by the paralyzed muscles of the left side, the patient frequently throws himself prone, in which position he struggles, moans and occasionally bites his tongue. The respiratory muscles are implicated, seriously disturbing the respiratory act and the right thumb is drawn into the palm. At the end of a short time (from one-half to three-fourths of a minute), the voluntary muscles become quiescent for one-half minute and then the clonic convulsions begin again. Sometimes the first convulsive attack lasts three minutes, to be followed by half a minute of repose. During all these movements both left extremities remain perfectly limp.

March 3d, 1903. Both the flexors and the extensors of the left forearm and hand give electro-reaction, but voluntary motion of forearm is almost nil and there is marked wrist drop. Muscles of the left great toe respond slightly to faradic current. The left hand is still anesthetic; there is atrophy of the left spinatus muscles and the left forearm and finger muscles. The left arm measures 1 1-2 inches less than the right arm. To prevent this atrophy, the faradic current and massage have been used during the last five months. The left ankle is now quite edematous and the finger and toe nails are yellow, rough, ridged and brittle. The mind is clear. He still insists that he will soon be down town on his crutches. He still has nocturnal convulsions.

In differentiating this case, the following summary may be useful:

First—A man of fifty-nine years of age, in the full vigor of an active and successful life, claims he has been hit on his head; a stone is found near his body in the railway coach and his scalp is contused. Second—At the end of twenty minutes he becomes comatose and has clonic convulsions of all the skelatel muscles. Third—Thirty-six hours thereafter consciousness is regained, but convulsions continue to recur at intervals of from one to two hours; marked impairment of ideation with slight aphasia. Fourth—Right monocular nasal hemiopia, which passes away after thirty days. Fifth—Left hemiplegia with recurring epileptiform convulsions affecting right side only. Sixth—Nurse states patient was seen to carry paralyzed hand and forearm about quite freely during sleep. Seventh—Temperature is above normal much of the time for a period of

six weeks. Eighth—Respiration often very irregular and pulse often abnormally slow. Ninth—Urine fourteen to eighteen ounces daily during several months. Ten—Anesthesia and analgesia in left half of body except face. Eleventh—While right side of skeletal muscles is convulsed, the left side remains motionless; patient often passes from sleep into fit. Twelfth—Plantar reflex acute in right foot, nil in left foot. Thirteenth—Electromuscular reaction normal on right side, nil on left. Fourteenth—Patient expresses a strong desire to recover.

The diagnosis of "voluntary convulsions" is absolutely untenable, for the convulsions recur during sleep while volition is in abeyance. It should be said in justice to the physician who made such a diagnosis that he has not seen the patient since the convulsions recur only at night during sleep.

That the case presents many of the manifestations of hysteria is quite true; for instance, clonic convulsions of the skeletal muscles on right side, while those on left side are flaccid; monocular hemianopsia without opthalmoscopic evidence of retinal disturbance, and fits lasting for several minutes, broken by periods of repose. But the diagnosis of hysteria is as untenable as that of voluntary convulsions, for the paralyzed muscles have lost their power of electrical reaction. In hysteria the muscles react normally to the faradic current. We still have the statement of the nurse that she saw patient carry his unaided hand to his head on three occasions during sleep. If the patient did this muscular feat during sleep, he could do it when awake, and such an act would be absolutely fatal to any theory in the case, except that of malingering.

Keeping in mind the physiologic and pathologic facts described, we are compelled to say that the nurse has discredited herself and she is not a competent witness—she has certified to a movement which was not made, the patient did not carry his hand to his head, because the nervous connection between the volitional center and the muscles of the left forearm was broken. The diagnosis is not difficult to arrive at. It is a case of endocranial hemorrhage.

Thanks to a host of able investigators who have done so much in cerebral localization, the pathology of this case can be determined by a study of the symptoms. The mariner's compass points to the north with no more certainty than motor paralysis of the left forearm and hand point to that portion of the certical surface of the right hemisphere near the longitudinal sinus, along the fissure of Rolando. The lesion is hemorrhagic, for it developed some minutes after the head was struck; it involves the cortex, because it causes convulsions as well as paralysis; it is in the upper and middle Rolandic regions. A blood clot formed anterior to the optic commissure and pressed upon the outer side of the right optic nerve, causing loss of sight in the left half of the right eye. This pressure has been removed by absorption, as is evidenced by the present condition of the right eye.

The treatment of the case has been much too conservative. The splendid results of surgical work in meningeal hemorrhage during the last ten years have taught the advisability of prompt action in these cases.

The skull should have been trephined and an effort made to remove the clot. Such a course was offered to the patient, but he rejected it, preferring rather to depend on nature's efforts to repair the damage. Those physicians who thought he was not seriously injured and believed he was malingering thought they saw in his refusal to be operated on evidence of the fact that the patient was playing a part and that he knew an operation was not needed.

DISCUSSION.

Dr. H. G. Brainerd, Los Angeles—This paper is particularly difficult to discuss, but it seems to me that the doctor's diagnosis does not cover all the points. How to explain a left hemoplegia from a cerebral lesion which produces motor paralysis is difficult to explain. It would seem that there was a great mixture of organic lesion with hysterical symptoms. I do not know any anatomical or physiological means of producing a left anesthesia and degeneration of muscles of the left side in the manner suggested.

Dr. MacBride, Pasadena—There is one characteristic thing in these cases of dural hemorrhage; that is, rather irregular distribution of the paralysis. The dura is supplied by the anterior and middle meningeal arteries. A lesion of the dura to produce convulsions must involve the inner surface of the dura. Sometimes we have these irregular dural convulsions caused by spicula of bone; sometimes by external hemorrhage, but, of course, pressure on the cord producing irregular convulsions must be considered in order to do this. As a rule dural convulsions are due to subdural hemorrhage. There is only one lesion that can do this. That is subdural hemorrhage by spicula of bone. There must have been some injury at the base of the brain. There have been a few cases reported in which with very minute cortical lesions independent of traumatisms there has been marked atrophy on the opposite side. The treatment was too conservative. I think brain surgery has shown brilliant results. The operations for tumors, abscesses, or cysts have not shown the brilliant results that trephining has. Dr. Starr in New York showed me a patient who had a hemorrhage on the left side with complete paralysis. He had subdural hemorrhage. Operated on about three weeks after and took out a large clot and the patient completely recovered. If this man were let alone he might have recovered, but ultimately when the clot had absorbed and the cicatrix contracted, he might have had paralysis. The atrophy on the left side would probably indicate some lesion on the left side and the same thing might produce the anesthesia.

Dr. William Franklin Barbat, secretary of the San Francisco County Medical Society, was married on January 23d to Miss Emilie M. Kane.